STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	09/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaints IN00094662 and IN00095771. This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 07/20/11. Complaints IN00094662 and IN00095771- Substantiated, Federal/State deficiencies related to the allegations are cited at F225, F226, and F323. Survey dates: August 28, 29, 30, and 31, 2011 and September 1, 2011 Facility number: 000253 Provider number: 155362 AIM number: 100266660 Survey Team: Kelly Sizemore, RN-TC Sheila Sizemore, RN (August 29, 30, and 31, 2011 and September 1, 2011) Marcia Mital, RN (August 28, 30, and 31, 2011) Janelyn Kulik, RN (August 28, 29, 30, and 31, 2011) Regina Sanders, RN (August 30, and 31, 2011 and September 1, 2011)	F0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Census bed type: SNF/NF: 156 Total: 156 Census payor type: Medicare: 20 Medicaid: 117 Other: 19 Total: 156 Sample: 14 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on 9/6/2011 by Bev Faulkner, RN			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to complete a thorough investigation for injuries of unknown origin and failed to notify ISDH (Indiana	F0225	F225 Resident #B no longer resides at the facility. No other residents have been found to have injuries of unknown origin that have not been reported in accordance with State law and	09/16/2011

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	State Department of Health) of the injuries in a timely manner for 2 of 3 residents reviewed for injuries of unknown origin in a total sample of 14. (Resident #B and #C) Findings include: 1. Resident #B's record was reviewed on 08/30/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, dementia, osteopenia, iron deficiency anemia, and anorexia with weight loss. A Quarterly MDS Assessment, dated 07/07/11, indicated the resident had a cognition score of 5 (impaired). A laboratory test, dated 08/18/11, indicated the resident's prothrombin time (blood clotting time) was 19.4 (normal 20.7-30.5) and the INR (international normalized ratio) (measures clotting time) was 1.92 (normal 2.00-3.00) A physician's order, dated 08/19/11, indicated to give Coumadin (blood thinner) 1 milligram every day. The resident's Nurses' Notes indicated: 08/23/11 at 4:48 a.m., "CNA pointed out resident has a large bruise to left lower anterior leg, 13 cm (centimeter) (l) (length) x 4.5 cm (w) (width). Resident		established procedure. Any residents found to have an injury of unknown origin will be thoroughly investigated by the ED or designee and promptly reported to the ISDH utilizing the guidelines of the ISDH titled "Reportable Unusual Occurrences." Staff has been inserviced on the correct reporting procedures.All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriations of resident property will be reported immediately to the ED of the facility and to other officials in accordance with State law and established procedures. All bruises of unknown origin will be submitted to the QA&A for review and recommendations. After six months if 100% compliance is noted then the QA&A committee will make recommendations whether to continue. Date of compliance is designated as September 16, 2011.	

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	does not know how it happened...No swelling noted...." 08/23/11 at 6:26 a.m., "Added note: resident's bruise is purple...." A facility investigation of the bruise, dated 08/23/11 at 5 a.m., indicated the bruise on the left leg was purple, and the resident was unable to explain how the bruise was obtained. The investigation indicated there was no swelling and no signs or symptoms of pain when the leg was palpated. The investigation indicated the facility had interviewed staff members. There was a lack of documentation on the investigation to indicate if it had been determined how the bruise had occurred. There was a lack of documentation to indicate the bruise had been reported to the ISDH, until 08/25/11 at 6 p.m., when the resident was assessed to have a left leg deformity. During an interview on 08/30/11 at 10:40 a.m., the Administrator indicated she had not reported the large bruise area because the resident was on a blood thinner. During an interview on 08/30/11 at 11:25 a.m., the Administrator indicated she felt the bruise was due to the Coumadin and			

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	didn't think the bruise needed to be reported because she attributed the size of the bruise to the Coumadin. During an interview on 08/30/11 at 2:05 p.m., the Administrator indicated she reported the bruise on 8/25/11, when there was a potential fracture of the leg and not within 24 hours. During an interview on 08/31/11 at 9:25 a.m., the Corporate Regional Manager indicated the facility could not determine a reason for the bruise so they felt it was from the Coumadin. 2. Resident C's record was reviewed on 8/30/11 at 9:45 a.m. Resident C's diagnoses included, but were not limited to, dementia, seizure disorder, and hypertension. A "RELEASE OF RESPONSIBILITY FOR LEAVE OF ABSENCE FROM THE FACILITY" form indicated the resident was signed out of the facility on 8/6/11 at 1:45 p.m., by a family member. It lacked a date and time the resident returned to the facility. Nurse's notes also lacked a date and time the resident returned to the facility. The Nurses' Notes indicated:			

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8/7/11 at 7:57 p.m., "Situation: Res (resident) noted with slightly swollen, slightly red area to rt (right) forehead (1.5 cm (centimeters) x (by) 1 cm) & swollen red area to lt (left) upper cheek (2 cm x 1 cm)...Assessment: No open area noted. No itching or discomfort noted...MD notified, continue to monitor. Family aware...."

8/8/11 at 4:09 a.m., "...Res continues with red swollen area to lt upper cheek & slight swelling to rt forehead. Swelling to rt forehead subsiding...."

8/8/11 at 12:34 p.m., "...staff to monitor red and swollen areas to the forehead and left cheek...."

A "VERIFICATION OF INVESTIGATION" form, dated 8/7/11 at 7:30 p.m., indicated it was the initial and follow-up report. It indicated the resident was unable to be interviewed due to cognitive deficits. Staff interviews indicated the resident went out to a family picnic and did not have the reddened or swollen areas when he returned, but in the a.m. of 8/7/11, red areas on forehead and left cheek were noted during a.m. care. Staff interviews indicated they might have been "bug bites" or "could have bumped himself on the foot of the bed, would not

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	lay at head of bed." The investigation lacked a family interview and did not have a final conclusion of what happened. During an interview with the DoN (Director of Nursing), on 8/30/11 at 11:30 a.m., she indicated when she assessed the resident, on 8/8/11 in the morning, "It wasn't a bug bite, it was more of an abrasion on the left cheek bone." She indicated they were not able to determine what happened and no one had interviewed the family. A "FAX JOURNAL REPORT," attached to the incident report, indicated the report was sent to ISDH on 8/9/11 at 7:28 p.m. During an interview with the Administrator, on 8/31/11 at 10:35 a.m., she indicated the report was not sent until 8/9/11. This federal tag relates to complaints IN00094662 and IN00095771. 3.1-28(c) 3.1-28(d)			

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F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow their policy for investigating injuries of unknown origin and failed to notify ISDH (Indiana State Department of Health) of the injuries for 2 of 3 residents reviewed for injuries of unknown origin in a total sample of 14. (Resident #B and #C) Findings include:	F0226	F226 Resident #B no longer resides at the facility. No other residents have been found to have injuries of unknown origin that have not been reported in accordance with State law and established procedure. Any residents found to have an injury of unknown origin will be thoroughly investigated by the ED or designee and promptly reported to the ISDH utilizing the guidelines of the ISDH titled "Reportable Unusual	09/16/2011

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	1. Resident #B's record was reviewed on 08/30/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, dementia, osteopenia, iron deficiency anemia, anorexia with weight loss. A Quarterly MDS Assessment, dated 07/07/11, indicated the resident had a cognition score of 5 (impaired). A laboratory test, dated 08/18/11, indicated the resident's prothrombin time (blood clotting time) was 19.4 (normal 20.7-30.5) and the INR (international normalized ratio) (measures clotting time) was 1.92 (normal 2.00-3.00) A physician's order, dated 08/19/11, indicated to give Coumadin (blood thinner) 1 milligram every day. The resident's Nurses' Notes indicated: 08/23/11 at 4:48 a.m., "CNA pointed out resident has a large bruise to left lower anterior leg, 13 cm (centimeter) (l) (length) x 4.5 cm (w) (width). Resident does not know how it happened...No swelling noted...." 08/23/11 at 6:26 a.m., "Added note: resident's bruise is purple...." A facility investigation of the bruise,		Occurrences." Staff has been inserviced on the correct reporting procedures. All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriations of resident property will be reported immediately to the ED of the facility and to other officials in accordance with State law and established procedures. All investigations of bruises of unknown origin will be submitted to the QA&A for review recommendations. After six months if 100% compliance is noted then the QA&A committee will make recommendations whether to continue. Date of compliance is designated as September 16, 2011.	

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	dated 08/23/11 at 5 a.m., indicated the bruise on the left leg was purple, and the resident was unable to explain how the bruise was obtained. The investigation indicated there was no swelling and no signs or symptoms of pain when the leg was palpated. The investigation indicated the facility had interviewed staff members. There was a lack of documentation on the investigation to indicate how the bruise had occurred. There was a lack of documentation to indicate the bruise had been reported to the ISDH, until 08/25/11 at 6 p.m., when the resident was assessed to have a left leg deformity. . During an interview on 08/30/11 at 10:40 a.m., the Administrator indicated she had not reported the large bruise area because the resident was on a blood thinner. She indicated she followed the facility's policy and procedure. An untitled policy and procedure, dated 01/04, and received from the Administrator as current, indicated, "...The facility will report resident contusions and lacerations meeting the following criteria: (**excluding residents receiving Anticoagulant Therapy) Contusions/Bruises 10 cm or larger on any resident...**Residents receiving			

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	Anticoagulant Therapy will be monitored by the facility in relation to contusions/bruising... Contusions/bruising will only be reported if assessment reflects that the bruising was not related to the Anticoagulant Therapy." During an interview on 08/30/11 at 11:25 a.m., the Administrator indicated she felt the bruise was due to the Coumadin and didn't think the bruise needed to be reported because she attributed the size of the bruise to the Coumadin. During an interview on 08/30/11 at 2:05 p.m., the Administrator indicated she reported the bruise when there was a potential fracture of the leg on 8/25/11 and not within 24 hours. During an interview on 08/31/11 at 9:25 a.m., the Corporate Regional Consultant indicated the facility could not determine a reason for the bruise so they felt it was from the Coumadin. 2. Resident C's record was reviewed on 8/30/11 at 9:45 a.m. Resident C's diagnoses included, but were not limited to, dementia, seizure disorder, and hypertension. A "RELEASE OF RESPONSIBILITY FOR LEAVE OF ABSENCE FROM THE			

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	FACILITY" form indicated the resident was signed out of the facility on 8/6/11 at 1:45 p.m. It lacked a date and time the resident returned to the facility. Nurses notes also lacked a date and time the resident returned to the facility. Nurses' notes on the following dates and times indicated: 8/7/11 at 7:57 p.m., "Situation: Res (resident) noted with slightly swollen, slightly red area to rt (right) forehead (1.5 cm (centimeters) x (by) 1 cm) & swollen red area to lt (left) upper cheek (2 cm x 1 cm)...Assessment: No open area noted. No itching or discomfort noted...MD notified, continue to monitor. Family aware...." 8/8/11 at 4:09 a.m., "...Res continues with red swollen area to lt upper cheek & slight swelling to rt forehead. Swelling to rt forehead subsiding...." 8/8/11 at 12:34 p.m., "...staff to monitor red and swollen areas to the forehead and left cheek... A "VERIFICATION OF INVESTIGATION" form, dated 8/7/11 at 7:30 p.m., indicated it was the initial and follow-up report. It indicated the resident			

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	was unable to be interviewed due to cognitive deficits. Staff interviews indicated the resident went out to a family picnic and did not have the reddened or swollen areas when he returned, but in the a.m. of 8/7/11, red areas on forehead and left cheek were noted during a.m. care. Staff interviews indicated they might have been "bug bites" or "could have bumped himself on the foot of the bed, would not lay at head of bed." The investigation lacked a family interview and did not have a final conclusion of what happened. During an interview with the DoN (Director of Nursing), on 8/30/11 at 11:30 a.m., she indicated when she assessed the resident, "It wasn't a bug bite, it was more of an abrasion on the left cheek bone." She indicated they were not able to determine what happened and no one had interviewed the family. A "FAX JOURNAL REPORT," attached to the incident report, indicated the report was sent to ISDH on 8/9/11 at 7:28 p.m. A facility policy titled, "REPORTABLE UNUSUAL OCCURRENCES," revised 1/25/06 and received as current by the Administrator, on 8/30/11 at 11:30 a.m., indicated "...PROCEDURE: Occurrences to be reported: Facilities are required by law to report unusual occurrences within			

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	24 hours of occurrence to the Long Term Care Division..."the facility must ensure that all alleged violations involving...injuries of unknown source...are reported...INJURIES OF UNKNOWN SOURCE: An injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person or the source of injury could not be explained by the resident; AND The injury is suspicious because of the extent of the injury or the location of the injury...FACILITY REPORTING AND INVESTIGATION INSTRUCTIONS: Facility must contact the ISDH (Indiana State Department of Health)...within 24 hours upon determining a situation exists...." During an interview with the Administrator, on 8/31/11 at 10:35 a.m., she indicated the report was not sent until 8/9/11. This federal tag relates to complaints IN00094662 and IN00095771. 3.1-28(a)			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure a resident's environment was free of accident hazards, related to transferring a resident with a mechanical lift with only one assistant. The resident was assessed to have a deformity of the lower left leg, which was diagnosed at the hospital as a fractured left tibia and fibula (lower leg bones). (Resident #B) Findings include: A, "Facility Incident Reporting Form", with an incident date of 08/24/11 at 4:30 p.m., indicated, "...Resident (Resident #B) presented with bruising that increased with possible fracture to leg...No known	F0323	F323 Resident #B no longer resides at the facility. No other residents have been found to have noted issues related to transfer via lift. All residents that are transferred via the lifts that are not on therapy caseload have been reviewed by an interdisciplinary team for appropriateness of lift use and number of required staff assistance. Staff have been in serviced on the use of the mechanical lifts including number of those designated for transfer. Residents that are transferred via lift have care plans updated to include the use of a mechanical lift with the assistance of two. Five transfers will be audited randomly on all three shifts by the DNS and/or designee daily five	09/16/2011

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	155362	A. BUILDING 00 B. WING	09/01/2011

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	fall recently, resident is dependent for mobility and transfers...Conclusion is fracture most likely occurred from positioning of leg in bed to elevate heel. With the movement of the ankle to reposition and the dx (diagnosis) of osteoporosis the gentle repositioning could have resulted in the fracture. Resident showed no signs of distress until positioning of the heel occurred at which time the aide observed the drop in the foot and notified nurse immediately...." The investigation by the facility, date 08/24/11, indicated LPN#1 was interviewed and LPN #1 indicated the resident had been sitting in front of the nurse's station and there was nothing unusual nor calling out by the resident. The facility interviewed CNA #2 (CNA who worked during the day shift on 08/24/11) on 08/26/11. CNA #2 indicated, she had transferred the resident with the "Marisa" lift (mechanical lift) when she got the resident out of bed. She indicated she had used the lift alone. She indicated the resident had not been in any pain and because she was a fall risk, she had taken the resident to sit by the nurses' station. CNA #2 indicated nursing students were in the room during the transfer of the resident with the mechanical lift.		days a week for thirty days then three transfers a day five days a week for thirty days and then two transfers a day five days a week to ensure that the appropriate number of staff are present. If compliance is not observed then affected staff will be re-inserviced. Audits will be submitted to QA&A for review for any noted patterns and/or recommendations. After six months if 100% compliance is noted then the QA&A will make recommendations whether to continue. Date of compliance is September 16, 2011.	

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The facility interviewed the Instructor of the nursing students on 08/29/11 and the Instructor indicated the students were observing care that day and not assisting.

The facility interviewed CNA #3 (CNA who had transferred the resident back to bed on 08/24/11) on 08/25/11. CNA #3 indicated when she arrived on the wing, the resident was in the hallway by the room and the resident had no facial grimaces or pain. She indicated she had transferred the resident to bed and the resident had voiced no complaints.

During a telephone interview, on 08/30/11 at 11:40 a.m., CNA #3 indicated she had transferred the resident from her chair to her bed with the mechanical lift. She indicated she had completed the transfer on her own. She indicated no other staff had assisted her with the mechanical lift. She indicated she transferred the resident to bed around 4 p.m., and the resident showed no signs of pain.

Resident #B's record was reviewed on 08/30/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, dementia, osteopenia, iron deficiency anemia, and anorexia with weight loss.

A right hip x-ray, dated 09/23/09,

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	indicated the resident had osteoporosis with osteoarthritis in the right hip. A, "Team Conference/Patient Rounds Form," signed by the physician on 08/05/11, indicated the resident was wheelchair bound, a mechanical lift was used for transfers, and the resident required maximum assistance for activities of daily living. The Annual Minimum Data Set (MDS) Assessment, dated 11/02/10, indicated the resident sometimes understood others and was sometimes understood, had cognitive pattern score of zero (impaired), and was dependent on two or more persons for transfers. The Care Area Assessment, dated 11/03/11, indicated the resident had difficulty maintaining a sitting balance and had impaired balance during transitions. The "Lift/Mobility Assessment for Residents," dated 11/02/10, indicated the resident could not bear weight on at least one leg, was able to follow simple instructions, was not able to grip with at least one hand and weighed less than 350 pounds. The form indicated the resident could be in a semi-reclined position and weighed less than 420 pounds. The form			

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	indicated the resident was a candidate for the Marisa lift and not the Sara (stand up) lift. The form indicated the resident required one staff member assistance for transfers. A quarterly clinical health status assessment, dated 07/02/11, the resident had unsteady balance with sitting and standing. A Quarterly MDS Assessment, dated 07/07/11, indicated the resident had a cognition score of 5 (impaired) and required extensive assistance of two or more for transfers. A care plan, dated 07/18/11, indicated the resident was at risk for falls related to a right below the knee amputation, history of falls, and dementia. The interventions included to use a mechanical lift for transfers. The resident's Nurses' Notes indicated: 08/23/11 at 4:48 a.m., "CNA pointed out resident has a large bruise to left lower anterior leg, 13 cm (centimeter) (l) (length) x 4.5 cm (w) (width). Resident des not know how it happened...No swelling noted...." 08/23/11 at 6:26 a.m., "Added note: resident's bruise is purple...."			

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08/23/11 at 8 p.m., "Resident resting in bed. Calm. Bruise to Left leg unchanged. No signs/symptoms pain to bruised area...."

08/24/11 at 2:06 a.m., "Resident in bed at this time, bruising remains to left anterior calf. No distress noted. No swelling noted to left leg."

08/24/11 at 3:30 p.m., "Resident up in w/c (wheelchair) in dining room...In no apparent distress."

08/24/11 at 4:30 p.m.,"Resident put back to bed...Increased bruising noted to LLE (left lower extremity). Lower left leg elevated on pillow, appears broken in appearance...."

08/24/11 at 5:55 p.m., "Resident transferred...Exhibits Pain to LLE with movement...."

Resident #B's hospital records were reviewed on 08/30/11 at 8 a.m.

A hospital history and physical, dated 08/24/11 at 9:52 p.m., indicated, "...possible fracture to left lower leg...Sent from the nursing home because of ecchymosis (bruising) and deformity to the leg...Patient is confused and can not

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	give any history...Physical Exam...Ht (height) 5' (feet) 4" (inches)...Wt (weight) 140 lb (pounds)...obese...only looks when her name is called. Does not follow instructions or answer questions...." A hospital left lower leg x-ray, dated 08/24/11, and report completed on 08/25/11, indicated, "...severe bruising and obvious deformity to left lower let. A spiral fracture is noted in the mid shaft through the proximal shaft of the tibia...Osteopenia of the bony structures is noted...Oblique fracture through the proximal shaft of the fibula is noted." During an interview on 08/30/11 at 2:05 p.m., the Administrator indicated the mechanical lift manufacturer's instructions indicated one caregiver could use the lift. During an interview on 08/30/11 at 2:15 p.m., the Director of Nursing (DoN) indicated the mechanical lift instructions indicated one person could use the lift. She indicated the CNA training book indicated there were supposed to be two people assisting with a mechanical lift transfer. A facility policy, titled, "Mechanical Lift, Hydraulic", received from the Administrator on 08/30/11 at 2:30 p.m., indicated, "PLACE THE			

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	MANUFACTURER'S INSTRUCTIONS FOR THE FACILITY MECHANICAL LIFT HERE." The Administrator indicated that was the only policy the facility had. The manufacturer's instructions, dated 04/10, indicated, "...Policy on Number of Staff members Required for Patient Transfer. (company name) passive and active series of lifts are designed for safe usage with one caregiver. There are circumstances,...obesity...etc. of the individual that may dictate the need for a two-person transfer. It is the responsibility of each facility or medical professional to determine if a one or two person transfer is more appropriate, based on task...capability, and skill level of the staff members." A professional resource, titled, "Indiana State Department of Health Division of Long Term Care Nurse Aide Training Program July 1998," Topic 22: Transferring, indicated, "...4. A mechanical lift...have at least one co-worker assist when using a mechanical lift...." This federal tag relates to complaints IN00094662 and IN00095771.			

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